Enclosure

Centers for Medicare & Medicaid Services – Special Terms and Conditions
<<< ***Project No. 21-W-00005/9*** >>>

I. PREFACE

The following are Special Terms and Conditions for the award of the California State Children's Health Insurance Program Demonstration (California Demonstration) request submitted under the Health Insurance Flexibility and Accountability Initiative (HIFA) on January 16, 2002. The Demonstration Populations are defined in the award letter that accompanies these Special Terms and Conditions.

The Special Terms and Conditions have been arranged into two broad subject areas: General Conditions for Approval, and Program Design/Operational Plan. In addition, specific requirements are attached and entitled: General Financial Requirements (Attachment A) and Operational Protocol (Attachment B).

The state agrees that it will comply with all applicable Federal statutes relating to Nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Letters, documents, reports or other material that is submitted for review or approval shall be sent to the California Demonstration Project Officer and the Associate Regional Administrator in the San Francisco Regional Office.

II. GENERAL CONDITIONS

A. The State shall prepare one protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and CMS during the course of the waiver negotiation and approval process. The protocol will be submitted to CMS for approval within 90 days of demonstration's approval date. During the demonstration, subsequent changes to the protocol which are the result of major changes in policy or operation procedures should be submitted no later than 90 days prior to the date of implementation of the change(s) for approval by CMS. The Special Terms and Conditions and Attachments include requirements, which should be included in the protocol. Attachment B is an outline of areas that should be included in the protocol.

B. The State will submit a phase-out plan of the demonstration to CMS six months prior to initiating normal phase-out activities and, if desired by the State, an extension plan on a timely basis to prevent disenrollment of enrollees if the waiver is extended by CMS. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS review and approval.

C. CMS may suspend or terminate any project, in whole or in part, at any time before the date of expiration whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal close out costs.

D. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the waiver is withdrawn, CMS will be liable for only normal close out costs.

E. All requirements of the Medicaid and SCHIP programs expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, shall apply to the California Demonstration.

F. The State shall, within the time frame specified in law, come into compliance with any relevant changes in Federal law or regulations affecting the SCHIP program that occur after the demonstration award date. The State may submit

to CMS a request for an amendment to the demonstration to request exemption from changes in law occurring after the demonstration award date.

G. The Demonstration populations will be subject to the same rules, policies and procedures as the population under the title XXI State plan unless otherwise specified in the award letter. In addition, the Demonstration Populations will be subject to the rules, policies and procedures specified in the State's approved HIFA proposal.

III. PROGRAM DESIGN/OPERATIONAL PLAN

A. Concurrent Operation

The State's title XXI state plan, as approved, will continue to operate concurrently with this section 1115 demonstration.

B. Maintenance of Coverage and Enrollment Standards for Children

1. The State shall not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI state plan as of January 1, 2002 while the demonstration is in effect.

2. The State shall, throughout the course of the demonstration, continue to show that it has implemented procedures to enroll and retain eligible children for Medi-Cal and SCHIP.

3. The State will establish a monitoring process to ensure that expenditures for the HIFA demonstration do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriated state match. The State will use title XXI funds to cover services for the SCHIP and HIFA populations in the following priority order:

    1) Individuals eligible under the title XXI State plan.
    2) Demonstration Populations 2, 3, and 4 with respect to children.
    3) Demonstration Population 1, the uninsured parents, relative caretakers and legal guardians of Medicaid and SCHIP children with net family incomes below 200 percent of the FPL.
    4) Demonstration Populations 2, 3, and 4 with respect to uninsured custodial parents, relative caretakers and legal guardians.

4. If the State exhausts the available title XXI Federal funds in a Federal fiscal year during the period of the demonstration, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and the Demonstration Populations with State funds:

    1) unless and until the State notifies CMS of specific State legislative or appropriations limitations that would preclude such continuation; or

    2) until further title XXI Federal funds become available.

    All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the Demonstration Populations. Before closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.

C. Coordination with Private Insurance Options

1. California will explore the feasibility of implementing a pilot program for employer-sponsored insurance (ESI) coverage. The State will initiate the assessment by July 1, 2002 and will complete the assessment by October 31, 2003. Upon completion, the State will advise CMS of its findings and conclusions. If CMS and the State mutually agree that it is feasible, the State will implement an ESI pilot within six months after receiving CMS approval and legislative authority. As part of any pilot, the State will monitor aggregate costs for participants to ensure that costs are not significantly higher than they would be in the absence of the pilot.

D. Two Month Demonstration Coverage Period

1. Individuals who were previously enrolled in Healthy Families (SCHIP) will continue to receive services as if they were enrolled in Healthy Families until they are found Medi-Cal eligible and moved into a Medi-Cal health plan, or the two month demonstration coverage period has ended. While a two month demonstration coverage period has been approved, the State shall determine Medi-Cal eligibility, terminate Healthy Families enrollment, and move individuals into the Medi-Cal health plan as soon as it is administratively possible. However, demonstration eligibility will end if the individual is found ineligible for Medi-Cal.

2. Individuals who were previously enrolled in Medi-Cal will continue to receive services as if they were enrolled in Medi-Cal until they are found potentially eligible for Healthy Families and enrolled in a Healthy Families health plan or the two month demonstration coverage period has ended. While a two month demonstration coverage period has been approved, the State shall determine Healthy Families eligibility, terminate Medi-Cal enrollment, and move individuals into a Healthy Families health plan as soon as it is administratively possible. However, demonstration eligibility will end if the individual is found ineligible for Healthy Families.

E. Enrollment Data and Tracking Requirements

<u>Quarterly Reporting</u>

1. The State will provide CMS with copies of the following enrollment reports quarterly beginning 60 days following the first quarter after the effective date for parent coverage (information that cannot be reported via SEDS should be reported in hard copy):

    - Actual and unduplicated enrollment of the Demonstration Population 1, by income, gender, and race/ethnicity.
    - Number of children whose eligibility for SCHIP was up for redetermination and number of adults whose eligibility for the demonstration was up for redetermination.

- Number of children who were redetermined at Healthy Families (HF) to be eligible for SCHIP and number of adults who were redetermined at HF to be eligible for the demonstration.
- Number of children and number of adults who used the two-month bridge in transitioning from Medi-Cal to SCHIP and from SCHIP to Medi-Cal.
- Number of children who were enrolled in Medi-Cal through accelerated enrollment.
- Number of children who applied for SCHIP and number of adults who applied for the demonstration but were denied for, at a minimum, the following reasons: income; failure to complete the application process; enrollment in other government programs; coverage by private insurance; or residence in another State.
- Number of children eligible for Medi-Cal in the last month of a quarter who have had continuous eligibility for at least 14-months. Children will be defined as those under age 19, to be consistent with the Healthy Families Program.
- Number of children who applied for Medi-Cal in the last month of a quarter who were denied for given reasons, based on reporting from counties able to do such reporting (currently only available from the LEADER system in Los Angeles County). The reasons include: death of applicant, application withdrawn, lack of California residency, no deprivation, excess resources (e.g., for those with income above the levels for the federal poverty level programs), failure to cooperate/loss of contact and other.

2. As part of the quarterly enrollment reports, the State will include a separate section to report on progress toward agreed-upon goals for reducing the rate of uninsurance. From data that are readily available, the State will also monitor the private insurance market (e.g., changes in employer contribution levels (if possible, among employers with low-income populations), trends in sources of insurance, etc.) and other related information in order to provide a context for interpreting progress toward reducing uninsurance. The State will also continue to monitor substitution of coverage (i.e., participants dropping private coverage).

<u>Annual Reporting</u>

3. The State will provide CMS with the following reports annually:

- Number of children who were disenrolled from SCHIP and number of adults who were disenrolled from the demonstration for, at a minimum, the following reasons: increase or decrease in income; failure to complete the renewal process; failure to pay premiums; enrollment in other government programs; purchase of private coverage; or residence in another state.
- Number of children who were disenrolled from Medi-Cal for: failure to cooperate, loss of state residence and other categories reported by counties.
- Results from the monitoring plan (see Attachment B: Operational Protocol)

F. General Reporting Requirements

1. Through at least the first six months after implementation, CMS and the State will hold monthly calls to discuss progress.

2. The State will submit quarterly progress reports, which are due 60 days after the end of each quarter. The reports should include, as appropriate, a discussion of events relating to the Demonstration Populations that occurred during the quarter. CMS will provide the State with a format to address the following: health care delivery; the enrollment process for newly eligible adults; enrollment and outreach activities; access; complaints and appeals to the State; monitoring activities (including the enrollment and tracking requirements outlined above in section E1 and E2), corrective action plans resulting from monitoring activities, survey results and other operational and policy issues. The report should also include proposals for addressing any problems identified in the report.

3. The State will submit an annual report no later than January 1 following the end of each Federal fiscal year. CMS will provide the State with a format to address the following: accomplishments; project status, including a budget update; quantitative and case study findings; policy and administrative difficulties; and progress on conducting the demonstration evaluation, including results of data collection and analysis of data to test the research hypotheses (including the enrollment and tracking requirements outlined above in section E3).

4. At the end of the demonstration, a draft final report should be submitted to CMS for comments. CMS's comments must be taken into consideration by the state for incorporation into the final report. The state should use the CMS, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

ATTACHMENT A

FINANCIAL REQUIREMENTS

1. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved SCHIP plan and those provided through the California Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal Financial Participation (FFP) only for allowable California Demonstration expenditures that do not exceed the State's available title XXI funding.

2. a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid Budget and Expenditure System (MBES), as part of the routine quarterly CMS-21 Waiver/CMS-21P Waiver reporting process. Title XXI demonstration expenditures will be reported on separate Form CMS-21, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

   b. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

   c. The standard SCHIP funding process will be used during the demonstration. California must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

d. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

3. California will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including available reallocated funds and any additional Federal funds made available to the State for purposes of title XXI. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the separate child health program or demonstration until the next allotment becomes available.

4. Total Federal title XXI funds for the State's SCHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds, and any additional Federal funds made available to the State for purposes of title XXI. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

5. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed ten percent of total title XXI expenditures.

ATTACHMENT B

OPERATIONAL PROTOCOL

The State will be responsible for developing a detailed protocol describing this demonstration. The protocol will serve as a stand-alone document that reflects the operating policies and administrative guidelines in the demonstration. The protocol will be submitted to CMS for approval within 90 days of the demonstration's approval date. The State shall assure and monitor compliance with the protocol. The protocol will include descriptions of the following:

1. The administration that will be in place to implement, monitor, and run the demonstration, and the tasks that each entity will perform.

2. How administration of the demonstration will be coordinated with the SCHIP and Medicaid programs.

3. The eligibility criteria and enrollment process and how it will be coordinated and tracked, particularly when parents and children on the same application are found eligible for different programs. This is to include the process for forwarding applications to SCHIP for those who apply for SCHIP/Medi-Cal at the county Medi-Cal offices and are determined ineligible for Medi-Cal or for those enrollees who lose Medi-Cal eligibility. Conversely, include the process for applications sent to the counties from SCHIP. A detailed description of accelerated eligibility for Medi-Cal eligible children should be included. The State should detail the eligibility and enrollment process of legal guardians whose children are enrolled in Medi-Cal or SCHIP. Timeframes for processing applications and enrollment should be included in the description. Also included should be a discussion of 12-months of continuous eligibility for those parents, relative caretakers, and legal guardians included in the demonstration population. Also addressed should be the steps the State intends to take to enhance the MEDS system's capabilities such that all eligibility determinations (approvals and denials) are posted on MEDS.

4. The redetermination process and how the demonstration project will be monitored, tracked and claimed. Please include a discussion of how the State will assure that within the two-month available demonstration coverage period, individuals are enrolled in the program for which they are eligible and disenrolled from the program for which they are no longer eligible.

5. The benefit package provided to the Demonstration Populations.

6. The delivery system for the Demonstration Populations, including enrollment practices that facilitate access to the system for family members. Included in the discussion should be the details of the delivery system for legal guardians whose children are eligible for Medi-Cal.

7. The process for determining whether the delivery system is adequate to support the addition of the demonstration populations and a plan for monitoring the system to ensure that it remains adequate.

8. The cost sharing requirements and procedures for ensuring that cost sharing does not exceed the limits described in the State's HIFA proposal.

9. The strategy for monitoring or preventing substitution of coverage under group health plans for the Demonstration Populations.

10. The monitoring plan to ensure that demonstration eligibles and their children are effectively screened, enrolled and retained in the appropriate program within acceptable timelines. This plan will detail provisions that provide statistically valid samples within each category and reviews the coordination of the two programs in the following categories: family members in transition using the bridge program; family members referred from the Single Point of Entry (SPE) to the county; split families referred from SPE to the county; and Medi-Cal parents with asset tests. A timeline for this process will be provided. As part of the monitoring plan, the State shall discuss how it will address problems found through the monitoring and assure timely corrective action. Written reports of the monitoring results along with corrective actions and timelines will be provided to CMS as part of the quarterly narrative reports.

11. The evaluation plan, which outlines the demonstration hypothesis, objectives and research design. Data sources and analysis will be detailed. Ongoing results will be provided to CMS as part of the annual report.

12. The process for ensuring that care is not interrupted for the approved State plan population or the Demonstration Populations should the State expend the full amount of the available Federal funds during the demonstration period. This process may include closing enrollment or instituting a waiting list with respect to the Demonstration Populations.

13. A description of when title XIX or title XXI funds will be claimed, e.g., legal guardians, accelerated enrollment, the two-month available demonstration coverage period, etc.

14. The procedures for meeting the financial requirements as specified in Attachment A.